

DENTAL HYGIENE APPLICATION CHECK LIST

There are 3 ways to obtain a license as a dental hygienist in the State of New Jersey:

1. Licensure by N.E.R.B.
2. N.E.R.B. past five years
(If you took the N.E.R.B. more than five years ago, and are licensed in another state, you may apply by "N.E.R.B. past five years.") Candidates applying on this basis are required to submit proof of 10 hours of continuing education earned within 2 years of the application.
3. Licensure by credentials
(If you have a current license in another state, obtained by some other state or regional clinical examination, you may apply by "Licensure by credentials." Score reports of this examination must be submitted with application.) Candidates applying on this basis are required to submit proof of 10 hours of continuing education earned within 2 years of the application.

Use this check-list to determine that you have complied with all of the requirements. Once your application is received, a file will be established and you will be notified if any documents are missing. The Jurisprudence Exam can be taken at any time during this process. Please refer to the Jurisprudence Examination information enclosed with this packet.

Complete and return the Certification and Authorization Form For a Criminal History Background Check (now required by law). The fee for this service is \$78.00, which is to be paid directly to the vendor. Instructions will be provided in a follow-up letter once your application has been received and processed.

Application Fee *(Non-Refundable)*:

1. If you have taken the N.E.R.B. clinical examination please enclose a certified check or money order for \$75.
2. If you are applying through credentials (a licensee who has taken another state or regional clinical examination currently licensed in another state or jurisdiction) please enclose a certified check or money order for \$125.

Checks should be made payable to "State of New Jersey" and sent with this application to:

NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark, NJ 07101

Answer all questions on the application form.

Staple one passport size photograph to the front page of the application. Please sign and print your name along with the date on the back of the photo.

Enter your social security number.

Have your dental hygiene school(s) provide an official school transcript in a sealed envelope. **DO NOT** open the envelope. Attach each sealed transcript(s) with the application, or arrange to have the school(s) forward the transcript(s) directly to the Board office.

Make photocopies of the State Verification Form (SV1.DH) and mail to each state in which you hold (or held) a license. Each state must fill out the form, stamp it with their official state seal and mail it directly to:

NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark, NJ 07101

List the date that each exam was taken in the Examination History section.

Please have your official National Board scores sent directly to the Board office at:

NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark NJ 07101

Please use additional paper if you cannot fit all of your information in the space provided on this form. Make a notation by each question that more information has been attached. Please mark your attached answers with the same number corresponding to the question that you are answering.

If you have answered 'yes' to any of the child support questions (16-19), please attach an explanation on a separate piece of paper to this application form.

Fill out the Medical Conditions form (MC1.DH) from your packet and send back with your application.

Once the **entire application** has been completed, have it signed and sealed by a Notary Public.

Upon approval of your application you will be notified by letter and requested to provide your initial biennial license fee.

Staple a clear, full-face passport-style photograph (2" x 2") of your head and shoulders, taken within the past six months.



For Office Use Only

Application No. _____

Check or Money Order _____

Process Date _____

License No. _____

Application for Dental Hygiene License

Date _____

A nonrefundable application fee of \$75.00 for licensure by N.E.R.B. or N.E.R.B. past five years, or a \$125.00 non refundable application fee for licensure by credentials, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the fees are paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure process will be delayed until the fees are paid.)

The Board maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

1. Name _____ Date of birth: _____

Mr.

Mrs. _____ (_____)

Ms. Last name First name Middle initial Maiden Name

2. Address (Check box for "Address of Record.")

☐

Home:

Street or P.O. Box City State Zip code County

Telephone number (include area code)

E-mail address

☐

Business:

Name of company

Telephone number (including area code)

Street

City

State

Zip code

County

☐

Mailing:

Street or P.O. Box

City

State

Zip Code

County

6. **Other State Board Licenses**

For each state listed, Form SV1.DH (enclosed with this packet) must be completed by each licensing jurisdiction and sent to the Board office. (Please list all states in which you have or have had a license, including inactive or retired status. Attach a separate sheet of paper if necessary.)

State _____	Status _____	State _____	Status _____
State _____	Status _____	State _____	Status _____
State _____	Status _____	State _____	Status _____

GENERAL QUESTIONS

ALL QUESTIONS MUST BE ANSWERED. IF ANY ANSWER IS 'YES', PLEASE SUBMIT A COMPLETE AND ACCURATE EXPLANATION ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THE APPLICATION.

7. Have you taken any State Board or Regional Board Examination(s) and failed? ☐ Yes ☐ No
8. Has your license to practice dental hygiene now or ever been subject to disciplinary action in any state? (If "Yes," please explain on a separate piece of paper.) ☐ Yes ☐ No
9. Is there any action pending against you by any state licensing board? ☐ Yes ☐ No
10. List all names, address and dates of dentists where you have been engaged in the practice of hygiene (include period in Armed Services, and other positions in health, education, etc.)

11. New Jersey Law and Jurisprudence Exam: Date taken: _____ (Leave blank if exam has not yet been taken.)
12. Have you ever been summoned; arrested; taken into custody; indicted; convicted or tried; charged with; admitted into pre-trial intervention (PTI); pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense; in this or any other state or in a foreign country? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No
13. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to a plea of guilty, non vult, nolo contendere, no contest, or finding of guilt by a judge or jury. ☐ Yes ☐ No
14. Have you ever been a defendant in a malpractice suit? ☐ Yes ☐ No
15. Is there now, to your knowledge or belief, any action or investigation pending against you, by a regulatory agency, including but not limited to professional licensing agencies, Medicaid, Medicare, criminal authorities or any other government agency? ☐ Yes ☐ No

CHILD SUPPORT QUESTIONS

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions numbered 16 - 19 will result in a denial of licensure. Furthermore, any false certification may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

16. Do you currently have a child-support obligation? If yes, ☐ Yes ☐ No
- a. Are you in arrears in payment of that obligation? ☐ Yes ☐ No
- b. Does the arrears match or exceed the total amount payable for the past six months? ☐ Yes ☐ No
17. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No
18. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No
19. Are you the subject of a child-support-related warrant? ☐ Yes ☐ No

IF YOU HAVE ANSWERED 'YES' TO ANY OF THESE QUESTIONS (7 through 19), PLEASE ATTACH AN EXPLANATION TO THIS APPLICATION.

For office use only

New Jersey State Board of Dentistry

Please print your name: _____

Date _____

Questions 1 through 9 pertain to medical conditions and use of chemical substances. If you answer "Yes" to question 1, you must answer questions 2 and 3. If you have answered "No" to question 1, continue with questions number 4 through 9. If you answer "Yes" to question 7, answer question 8. Please read the definitions below carefully. Your responses will be treated confidentially, and retained separately. Please be aware that you have a right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing to the Board office and confirm that by the answer given to questions number 5 and 9. You must fully respond to all other questions on the application. Your application for licensure will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question which you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law (N.J.S.A. 45:1-20).

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice dental hygiene" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical findings and exercise reasonable dental hygiene judgments and to learn to keep abreast of dental developments; and
2. The ability to communicate those judgments and dental information to patients and to other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform dental tasks such as dental examination and dental hygiene procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? Yes ☐ No ☐
2. If you answered "YES" to question 1, are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**? Yes ☐ No ☐
3. If you answered "YES" to question 1, are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? Yes ☐ No ☐
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
(See Question 5 for the Fifth Amendment option before responding.) Yes ☐ No ☐
5. If you have chosen not to answer question 4 and instead have submitted a written Fifth Amendment assertion to the board office, check the "YES" box here. Yes ☐ No ☐
6. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? Yes ☐ No ☐
- If this question does not apply, check both the "No" box and the "Not Applicable" box. Not applicable ☐
7. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.")
See Question 9 for the Fifth Amendment option before responding. Yes ☐ No ☐
8. If you answered "YES" to Question 7, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ☐ No ☐
9. If you have chosen not to answer question 7 above and instead have submitted a written Fifth Amendment assertion to the Board office, check the "YES" box here. Yes ☐ No ☐

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.

"I certify that the information entered on this form is true and complete to the best of my knowledge, and further acknowledge that if the above information is willfully false, I am subject to punishment and/or disciplinary sanction including license suspension/revocation or the imposition of civil penalties as may be provided by law."

Signature of Licensee

Date

Print Name



State of New Jersey, County of _____, _____
Name of Applicant

of _____
Address of applicant

Waiver

I hereby authorize all hospitals or institutions or organizations, my references, employers (past and present), business and professional associations (past and present), and all governmental agencies and instrumentalities (local, state, Federal or foreign) to release to the New Jersey State Board of Dentistry any information, files or records requested by the Board in connection with the processing of this application. I further authorize the New Jersey State Board of to release to the organizations, individuals and groups listed above information which is material to my application.

I have carefully read the questions in the foregoing application and have answered them completely without reservation, and I declare under penalty of perjury that my answers and all statements made by me therein are true and correct. Should I furnish any false information in this application, I hereby acknowledge that such act shall constitute cause for the denial, suspension or revocation of my license to practice dentistry in the State of New Jersey.

I realize that the foregoing information is necessary for an evaluation of my application, of which this is a part, and I fully recognize that full disclosure is essential to such procedures.

I have read the above and fully understand the contents.

Signature of Applicant

Sworn and subscribed to before me this

_____ day of _____, 20____

Notary Public

DO NOT WRITE IN THIS SPACE

Date Received _____

Application Number _____

License Number _____

National Board
Certification Date _____

N.E.R.B.
Certification Date _____

N.E.R.B. Scores

COMP _____

CLIN _____

**New Jersey Board of Dentistry**

P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark, NJ 07101, 973-504-6405

Verification of State License - DENTAL HYGIENE

A separate form must be used for each state.

(This form may be reproduced.)

NAME OF APPLICANT: _____

First

Middle

Last

The above named applicant is a licensee of the State of _____, and was issued

license number _____ on _____
Month/Day/Year

The applicant was licensed by:

☐ State or Regional Clinical Examination *(Please list below.)*☐ N.E.R.B. _____
Date passed☐ National Hygiene Board Examination _____
Date passed☐ Endorsement/Reciprocity from the State of _____ ☐ Other *(Please list below.)*

The license status is:

☐ Current and in good status expiring on _____
Date☐ Revoked or Suspended☐ Inactive/expired on _____
Date☐ Other *(please attach explanation)***Examination History (If Applicable)**Date of ExaminationSubjectGradeThe licensee ☐ does ☐ does not have a record of disciplinary history with this agency.
(Attach additional information if applicable.)

I hereby certify that to the best of my knowledge and belief, the foregoing is a true statement of the record of the individual on this form.

Name of Board _____

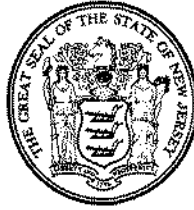
Name of Person Completing Form _____

Title _____

Signature _____

Date _____

(Board Seal)



New Jersey State Board of Dentistry Jurisprudence Examination

Please use the small white booklet, the New Jersey State Board of Dentistry book of Statutes & Regulations, to prepare for the Jurisprudence examination.

If you are a New Jersey resident:

All New Jersey residents are required to take the Jurisprudence Examination at the Board of Dentistry administrative offices in Newark, New Jersey. If you are a New Jersey resident, or an out of state resident who will be in the area, please use the attached form to schedule a time to take the exam.

If you live outside of New Jersey:

You may have the Jurisprudence exam proctored if you live out of state. Proctored tests can be handled in the following ways:

- a. Individuals requesting the Jurisprudence Exam may have their exam proctored by a licensed dentist.
- b. Students requesting the Jurisprudence Exam may have their exam proctored by a faculty member from their school.

Anyone requesting to proctor the Jurisprudence Examination may write a letter to the Board. The letter should include the following information:

1. Number of exams requested.
2. Date of examination.
3. Type of examination: Dental, RDH or RDA.
4. Name, address, institution and title of proctor.
5. Contact name and phone number.
6. Address where exam(s) should be mailed.

This letter may either be faxed to: 973-273-8075, or sent by mail to:
NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark NJ 07101

**New Jersey State Board of Dentistry
Jurisprudence Examination
Registration Form**

If you are a New Jersey resident (or out of state resident wishing to take the Jurisprudence Exam at the Board's administrative office), please check off which date and time you would like to take the test. Please send this form back via fax or mail it to the address below. You will have one hour to complete this closed book examination.

<input type="checkbox"/> April 7	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> April 21	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> May 5	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> May 19	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> June 9	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> June 23	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> July 7	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> July 21	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> August 4	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> August 18	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> September 8	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> September 22	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> October 6	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> October 20	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> November 3	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> November 17	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> December 1	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.
<input type="checkbox"/> December 15	<input type="checkbox"/> 10:00 a.m.	<input type="checkbox"/> 1:00 p.m.

Candidate Name _____

Daytime Phone Number _____

Please check off one: ☐ Dental ☐ RDH ☐ RDA

Return this form to: Board of Dentistry
124 Halsey Street
Newark, NJ 07101

Fax Number: 973-273-8075

Official Use Only☐ Dual LicenseLicense Type 1
_____Applicant's Number
_____License Type 2
_____Applicant's Number
_____**New Jersey Office of the Attorney General**Division of Consumer Affairs
New Jersey State Board of Dentistry
P.O. Box 45005
Newark, New Jersey 07101
(973) 504-6405**Official Use Only**☐ ResubmitBoard or Committee
_____**CERTIFICATION AND AUTHORIZATION FORM
FOR A CRIMINAL HISTORY BACKGROUND CHECK****Directions:** Answer all of the questions on this form.1. Name _____ (_____)
Last First Middle Maiden Name2. Address _____
Street or P.O. Box City State ZIP code3. Date of birth ____/____/____ Sex: ☐ Male ☐ Female
Month Day Year

4. Social Security number _____ / _____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No

If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.

If "Yes," please provide the following information and follow the instructions outlined below:

Board or committee requiring the fingerprinting_____
Month and year you were fingerprintedIf you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs**, you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. The fee for this background check will be \$33.00. Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No**Every such conviction on record must be disclosed.** A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.****Note:** Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.**Your continuing responsibility to disclose convictions of crimes or offenses:** You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature of applicant

Date